Department of Health
Office of Emergency Medical Services & Trauma System

SERVICE / VEHICLE RELICENSURE APPLICATION

Service Name: _____ / _____
(Legal Name) *(Also Known As)*

Address: _____ EMS Agency/License #: _____

_____

City: _____ State: _____ Zip: _____

Owner/Operator: _____ Phone: _____

EMS Representative: _____ Phone: _____

E-Mail Address: _____ FAX: _____

NOTE: This application may NOT be used to upgrade or change your agency's type of service license. Please contact our office for the appropriate forms needed to apply for a service type other than what you currently hold.

TYPE OF SERVICE (choose one only): Ambulance (Transport) ☐ Aid Service (Non Transport) ☐

IF YOUR RESPONSE *AREA* AND/OR RESPONSE *TIMES* HAVE CHANGED SINCE YOUR LAST APPLICATION, PLEASE ATTACH A WRITTEN EXPLANATION TO THIS APPLICATION.

WOULD YOU LIKE TO CONTINUE YOUR VERIFIED STATUS? ***Yes** ☐ No ☐ N/A ☐

***IF 'Yes', WHAT IS THE HIGHEST LEVEL OF CARE PROVIDED ON A 24-HOUR BASIS?** BLS ☐ ILS ☐ ALS ☐

ORGANIZATION TYPE: (check the one that ***best*** applies to your organization)

Private for profit	☐	Fire District	☐	Law Enforcement	☐
Private non-profit	☐	City Fire Dept.	☐	Municipal (city/county)	☐
Private volunteer association	☐	Industrial Fire Dept.	☐	Search & Rescue	☐
Hospital District	☐	City/Fire Dist. Comb	☐	Other (*please specify below*)	☐
EMS District	☐	Federal Fire Dept.	☐	_____	

VEHICLES: Please provide the **number** of each type vehicle you are licensing (from Page 2):

Ground Ambulance ☐ Aid Vehicle (Non-Transport) ☐

RESPONSE INFO: Please provide the **number** for each EMS activity listed below, for your last full calendar year**:**

Primary Responses ☐ Transports Primary/Secondary ☐
Secondary Responses ☐ Interfacility Transports *Only* ☐

PERSONNEL STATUS: Are your EMS personnel primarily: (*check one*) Paid ☐ Volunteer ☐

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SERVICE / VEHICLE RELICENSURE APPLICATION
GENERAL OPERATION

Please describe the **general operation** of your service; including how it will operate in a manner consistent with WAC 246-976, the Regional Plan, and approved Regional Patient Care Procedures. *(Please find this information on our website at **www.doh.wa.gov/hsqa/emstrauma** **click on "Licensure Processes."** If you require hard copies of this information, please contact the Licensing and Certification office, shown at the bottom of this application).* Provide an explanation of your:

1. **Dispatch plan**

2. **Response plan**

3. **Response area**

4. **Type of transport (emergency and/or interfacility), if any**

5. **Tiered response and rendezvous, if any**

6. **Back-up plan to respond (may not apply to agencies doing interfacility transports only)**

NOTE: Other services involved in your response plan must be informed by you that they are participants and identified in number 6 above. These agencies must agree to that participation. Attach extra sheets as necessary.

"I hereby affirm and declare that the information provided on this application is true and correct, and that:

1. *We operate in a manner that is consistent with the Regional Plan and pre-hospital patient care procedures;*
2. *The vehicles identified on the attached page meet the minimum equipment requirements for the type of licensure and/or verification requested by our service;*
3. *We meet the minimum staffing requirements for licensure and/or verification as identified on the attached page;*
4. *Our EMS Personnel utilize DOH approved Medical Program Director (MPD) protocols; and*
5. *We maintain current liability insurance coverage."*

Person Completing Application ***(Please Print)*** **Date**

Owner/Operator ***(Signature & Title)*** **Date**

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